UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

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UNITED STATES OF AMERICA,

Plaintiff,

v.

MATTHEW H. PETERS, BAYVIEW SPECIALTY SERVICES LLC, COASTLINE SPECIALTY SERVICES LLC, STRAND VIEW CORPORATION, INNOVATIVE SPECIALTY SERVICES LLC, PARAGON PARTNERS LLC (D/B/A PARAGON MEDICAL PARTNERS), CARDEA CONSULTING LLC, PRAXIS MARKETING SERVICES LLC, PROFESSIONAL RX PHARMACY LLC, INLAND MEDICAL CONSULTANTS LLC (D/B/A ADVANCED THERAPEUTICS), PORTLAND PROFESSIONAL PHARMACY LLC, SUNRISE PHARMACY LLC, PROFESSIONAL 205 PHARMACY LLC (D/B/A PROFESSIONAL CENTER 205 PHARMACY), SYNERGY MEDICAL SYSTEMS LLC (D/B/A SYNERGY RX), SYNERGY RX LLC (D/B/A SYNERGY RX), PRESTIGE PROFESSIONAL PHARMACY, JMSP LLC (D/B/A PROFESSIONAL CENTER 205 PHARMACY), MPKM, LLC (D/B/A PROFESSIONAL CENTER PHARMACY), ONE WAY DRUG LLC (D/B/A PARTELL PHARMACY), PARTELL PHARMACY LLC, OPTIMUM CARE PHARMACY INC. (D/B/A MARBELLA PHARMACY), GLENDALE PHARMACY LLC, and LAKE

No. 2:24-cv-00287 WBS CKD

MEMORANDUM AND ORDER RE: DEFENDANTS' MOTIONS TO DISMISS

FOREST PHARMACY (D/B/A LAKEFOREST PHARMACY),

Defendants.

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The United States brought this action against Matthew Peters and several pharmacies and other corporate entities, alleging that they operated a kickback scheme that submitted claims for prescription medications to federal government insurance programs in violation of the False Claims Act. (First Am. Compl. ("FAC") (Docket No. 5).) Before the court are defendants' motions to dismiss. (Docket Nos. 21, 32, 33.)

I. The Parties[1]

Defendant Matthew Peters is an individual who controlled or operated the various pharmacies and other corporate defendants. (FAC ¶ 5.)

The pharmacy defendants are Professional Rx Pharmacy LLC, a Florida company with a registered address in Nevada; Inland Medical Consultants LLC d/b/a Advanced Therapeutics, a California company; Portland Professional Pharmacy LLC, an Oregon company; Sunrise Pharmacy LLC, a Nevada company; Professional 205 Pharmacy LLC d/b/a Professional Center 205 Pharmacy, an Oregon company; Synergy Medical Systems LLC d/b/a Synergy Rx, a Delaware company with its principal place of business in Oregon; Synergy RX LLC d/b/a Synergy Rx, a Delaware company with its principal place of business in Oregon; Prestige Professional Pharmacy, an Oregon company; JMSP LLC d/b/a Professional Center 205 Pharmacy,

[1] All facts recited in this Order are as alleged in the First Amended Complaint unless otherwise noted.

an Oregon company; One Way Drug LLC d/b/a Partell Pharmacy, a Nevada company; Partell Pharmacy LLC, a Nevada company[2]; Optimum Care Pharmacy Inc. d/b/a Marbella Pharmacy, a California corporation; Glendale Pharmacy LLC, a Missouri company with its principal place of business in Texas or Missouri; Lake Forest Pharmacy d/b/a Lakeforest Pharmacy, a Missouri company; and MPKM LLC d/b/a Professional Center Pharmacy, a Nevada company. (Id. ¶¶ 6-20.) All of the pharmacy defendants operated as mail-order pharmacies. (See id.)

The management service organization ("MSO") defendants are Coastline Specialty Services LLC and Bayview Specialty Services LLC, both Texas companies with principal places of business in Nevada. (Id. ¶¶ 23, 26-27.) The MSOs provided investment opportunities for physicians who prescribed to the pharmacy defendants. (Id. ¶ 24.)[3]

The marketing entity defendants are Paragon Partners LLC, a Nevada company; Cardea Consulting LLC, a Florida company; and Praxis Marketing Services LLC, a Florida company. (Id. ¶ 29-

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[2] Defendant Partell Pharmacy LLC requests that the court take judicial notice of documents related to pharmacy licensing, arguing that Partell Pharmacy is not actually a pharmacy. The government disputes this representation and requests judicial notice of other documents that it argues establish Partell is a pharmacy. Because the issue of Partell's status as a pharmacy is subject to "reasonable dispute" by the parties, the court DENIES both requests for judicial notice. See Fed. R. Evid. 201(b). The complaint alleges that Partell is a pharmacy, which the court must take as true at this stage of the proceedings.

[3] The two MSOs did not operate concurrently. The Coastline MSO operated from approximately June 2017 to September 2018, and was replaced by the Bayview MSO, which operated from approximately September 2018 to early 2020. (See FAC ¶¶ 26-27, 128.)

32.) The marketing entities paid sales representatives to promote the pharmacy defendants to physicians. (Id. ¶ 33.)

The other corporate defendants are Strand View Enterprises LLC, a Texas company with its principal place of business in Nevada; and Innovative Specialty Services LLC, a California company. (Id. ¶ 37, 41.) Strand View was an LLC member of the MSOs. (Id. ¶ 40.) Peters used Strand View as an intermediary to move money between the pharmacies, MSOs, and marketing entities. (Id. ¶ 38.) Innovative Specialty Services acted as a pass-through entity for "investments" going into the MSOs. (Id. ¶ 41.)

II. The Alleged Kickback Scheme

Peters created the MSOs as vehicles to induce physicians to send prescriptions to the pharmacy defendants. (Id. ¶ 85.) Physicians who sent prescriptions to the pharmacies at high enough volumes were offered the opportunity to buy "shares" in the MSOs. (Id. ¶ 88, 94.) The only other MSO "investor" was Strand View Enterprises, owned by Peters. (Id. ¶ 98.)

Each MSO had approximately sixty to ninety-five physician investors at a time. (Id. ¶ 90.) The number of shares available to physicians and the availability of further share buy-ins were proportional to the volume of prescriptions the physicians sent to the pharmacies. (Id. ¶¶ 94-96, 164-71.) Physicians who bought MSO shares received frequent financial payouts that were tied to the volume of prescriptions they sent to the pharmacies. (Id. ¶¶ 86-88.) Physician investors received high financial returns, regularly exceeding 500% of their initial

investment annually immediately upon buy-in. (Id. ¶ 99.)

The MSOs obtained the money paid to physician investors through "management services" arrangements with some of the pharmacies, which were the MSOs' sole revenue source. (See id. ¶ 116, 118, 130, 134.) Under these arrangements, pharmacies paid a large portion of their revenues to the MSOs. (See id. ¶ 120, 132.) The MSOs "served no independent business purpose other than to funnel money to physician investors in exchange for prescription volume." (Id. ¶ 142.)

Because MSO revenue was directly tied to the revenue of the pharmacies, this arrangement encouraged physicians to direct more prescriptions and costlier prescriptions to the pharmacies. (Id. ¶ 125.) The MSO distributions induced physician investors not only to direct more prescriptions to the pharmacy defendants (as opposed to other pharmacies), but also to prescribe greater volumes of medications overall. (Id. ¶ 158.) When physician investors' volume of prescriptions decreased, sales representatives pressured the physicians to increase their prescription volume. (Id. ¶¶ 186-94.)

From the perspective of the physicians, "there was no distinction between any of" the pharmacy defendants. (Id. ¶ 201.) Investors did not select among the pharmacies when issuing a prescription, as the pharmacies all used the same fax number and electronic prescribing platform. (Id. ¶ 202.)

Sales representatives paid by the marketing entity defendants advertised the MSO investment opportunity to encourage physicians to direct prescriptions to the defendant pharmacies. (Id. ¶ 103.) The sales representatives used meals, happy hours,

gifts, entertainment, cash payments, and free medications for in-clinic use -- all funded by the defendant pharmacies -- to induce physicians to prescribe to the pharmacies. (Id. ¶ 236, 243, 248.) All prescriptions to the pharmacy defendants came from physicians with one or more sales representatives assigned to work with them. (Id. ¶ 234.) In other words, the pharmacies did not do any business unconnected to the scheme. (See id.)

The defendant pharmacies submitted claims for prescription medications to various insurers, including federal health insurance programs like Medicare Part D. (See id. ¶ 106, 269.) From 2017 through the life of the scheme, the pharmacies received at least $8,115,998.38 from Medicare Part D plans for medications prescribed by physician investors. (Id. ¶ 206.) During that same period, the pharmacies were paid at least $33,219,567.96 from Medicare Part D plans for medications prescribed by physicians with sales representatives assigned to them (i.e., the entire group of physicians including both investors and those who had been solicited to prescribe to the pharmacies but were not investors). (See id. ¶ 235.)

III. False Claims Act

The False Claims Act ("FCA") "prohibits the submission of false or fraudulent claims to the federal government and imposes liability on an individual who 'knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval' or who knowingly makes a 'false record or statement material to a false or fraudulent claim.'" United States ex rel. Campie v. Gilead Sci., Inc., 862 F.3d 890, 899 (9th Cir. 2017) (quoting 31 U.S.C. § 3729(a)(1)(A)-(B)).

The government premises its FCA claims on violations of the Anti-Kickback Statute, which "states that whoever knowingly and willfully solicits, receives, offers, or pays any remuneration in exchange for referral of an individual for the furnishing of any item or service for which payment may be made under a Federal health care program shall be guilty of a felony." United States v. Kats, 871 F.2d 105 (9th Cir. 1989) (citing 42 U.S.C. § 1320a-7b(b)(1)-(2)). "A claim that includes items or services resulting from a violation of [the Anti-Kickback Statute] constitutes a false or fraudulent claim for the purposes of [the FCA]." 42 U.S.C. § 1320a-7b(g).

The government alleges violations of the FCA under several theories. The first claim alleges that Peters and the pharmacy defendants presented false claims; the second claim alleges that all defendants caused false claims to be presented; the third claim alleges that all defendants engaged in a conspiracy to present false claims; and the fourth claim alleges that Peters and the pharmacy defendants avoided their obligation to pay money owed to the government (i.e., a "reverse" FCA claim). However, all the FCA claims are based on the alleged submission of false claims by the pharmacies. See U.S. ex rel. Cafasso v. Gen. Dynamics C4 Sys., Inc., 637 F.3d 1047, 1055 (9th Cir. 2011) (the FCA "attaches liability, not to the underlying fraudulent activity or to the government's wrongful payment, but to the claim for payment") (cleaned up).

A. Rule 12(b)(6)

The court first disposes of defendants' argument that the government fails to state a "reverse" FCA claim under Rule

12(b)(6).

The "reverse" provision of the FCA prohibits knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the government. See 31 U.S.C. § 3729(a)(1)(G). As relevant here, recipients of Medicare payments have an "obligation" within the meaning of the FCA to "report and return" an overpayment within sixty days "after the date on which the overpayment was identified." See 42 U.S.C. §§ 1320a-7k(d)(1)-(3). Defendants argue that the complaint fails to identify any obligation to return funds to the government.

The complaint alleges that Peters knew the scheme violated federal law, pointing to investor presentations in which he referenced the requirements of the Anti-Kickback Statute and his efforts to conceal the fact that the MSO scheme involved prescription payments from federal government programs. (See FAC ¶¶ 196-200, 209-213.) Further, several physician investors' prescriptions to the defendant pharmacies were audited by Medicare, in response to which Peters allegedly fabricated back-dated prescription documentation and instructed physicians how to respond to auditors. (See id. ¶¶ 253-55.)

Taken as true and construed in the government's favor, these allegations indicate that Peters and the pharmacy defendants (all closely controlled by Peters) had notice the scheme was unlawful, triggering an obligation to repay the Medicare prescription payments. See United States ex rel. Martinez v. KPC Healthcare Inc., No. 8:15-cv-01521 JLS DFM, 2017 WL 10439030, at *6 (C.D. Cal. June 8, 2017) ("fraudulently

billing Medicare followed by a knowing subsequent retention of an overpayment may result in liability under the reverse false claims provision") (citing United States v. Mount Sinai Hosp., No. 13-cv-4735 RMB, 2015 WL 7076092, at *13 (S.D.N.Y. Nov. 9, 2015)); United States ex rel. Ormsby v. Sutter Health, 444 F. Supp. 3d 1010, 1078 (N.D. Cal. 2020) ("internal and external reviews of [allegedly false] diagnosis codes put the defendants on notice of the potential overpayments" from Medicare, triggering sixty-day repayment obligation). The court therefore declines to dismiss the fourth claim alleging reverse FCA violations on this ground.

B. Rule 9(b)

"[C]omplaints brought under the FCA must fulfill the requirements of Rule 9(b)." Bly-Magee v. California, 236 F.3d. 1014, 1018 (9th Cir. 2001). "Under Rule 9(b), a plaintiff 'must state with particularity the circumstances constituting fraud.'" United States ex rel. Swoben v. United Healthcare Ins. Co., 848 F.3d 1161, 1180 (9th Cir. 2016). "This means the plaintiff must allege 'the who, what, when, where, and how of the misconduct charged,' including what is false or misleading about a statement, and why it is false." Id. (quoting Ebeid ex rel. United States v. Lungwitz, 616 F.3d 993, 998 (9th Cir. 2010)).

Under Rule 9(b), "it is sufficient to allege 'particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted.'" Id. (quoting United States ex rel. Grubbs v. Kanneganti, 565 F.3d 180, 190 (5th Cir. 2009)). Nonetheless, the complaint still "must provide enough detail 'to

give [defendants] notice of the particular misconduct which is alleged to constitute the fraud charged so that [they] can defend against the charge.'" Ebeid, 616 F.3d at 999 (quoting U.S. ex rel. Lee v. SmithKline Beecham, Inc., 245 F.3d 1048, 1051–52 (9th Cir. 2001)).

The complaint adequately pleads that false claims were submitted. It describes the alleged scheme in great detail, as summarized above. The complaint also provides the total value of the Medicare claims associated with the scheme across all the pharmacies, gives examples of the value of Medicare claims submitted by select pharmacies, and specifically alleges that "each of the [pharmacies] billed Medicare part D plans for medications prescribed by physician investors." (See id. ¶¶ 107, 206-207, 235.) The government has plainly provided "particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted." See Swoben, 848 F.3d at 1180.

Defendants argue that the complaint fails to adequately distinguish among the organizational defendants. The Ninth Circuit has explained that pursuant to Rule 9(b), "a fraud suit against differently situated defendants must 'identify the role of each defendant in the alleged fraudulent scheme.'" United States ex rel. Silingo v. WellPoint, Inc., 904 F.3d 667, 677 (9th Cir. 2018) (quoting Swartz v. KPMG LLP, 476 F.3d 756, 765 (9th Cir. 2007)). "In other words, when defendants engage in different wrongful conduct, plaintiffs must likewise 'differentiate their allegations.'" Id. (quoting Swartz, 476 F.3d at 764). "On the other hand, a complaint need not

distinguish between defendants that had the exact same role in a fraud." Id.

With respect to the pharmacy defendants, the complaint explains that "[f]rom the perspective of the [physician investors], there was no distinction" between the pharmacies, which all "used the same fax number and electronic prescribing platform." (See FAC ¶ 201.) Many physicians were not even aware that Peters owned multiple pharmacies. (Id. ¶ 204.) Further, the pharmacies all played the same role in the alleged fraud: to receive prescriptions from physicians involved in the scheme, submit claims to health insurance programs for those prescriptions, and funnel money to the MSOs to provide payouts to physician investors, all under the direction of Peters. (See id. ¶¶ 6-22, 85-106, 116-19, 185-99.)

Because the pharmacies all played the "same role" in the centrally operated scheme, the government may collectively plead the allegations against the pharmacies. See WellPoint, 904 F.3d at 667, 678 ("[I]f a fraudulent scheme resembles a chain conspiracy, then a complaint must separately identify which defendant was responsible for what distinct part of the plan. By contrast, if a fraudulent scheme resembles a wheel conspiracy, then any parallel actions of the 'spokes' can be addressed by collective allegations."). The same reasoning applies to the marketing entity defendants, which all served identical roles of using revenue generated by the pharmacies to pay sales representatives who promoted the pharmacies to prescribers, all under the direction of Peters. (See FAC ¶¶ 29-36.)

With respect to the remaining organizational

defendants, the complaint adequately distinguishes among them to the extent there are differences in their roles. While the MSOs served identical functions and operated in largely the same manner under Peters' direction, the complaint does explain their differences, including that they operated during separate periods of time, had different numbers of physician investors, and utilized different methods for distributing funds to physician investors. (See id. ¶¶ 26-27, 115, 120-36, 142-58.) The complaint also differentiates between the two remaining corporate defendants -- which both served as intermediaries to move funds -- explaining that Strand View was an LLC member of the MSOs and served as the front for communicating with investors, while Innovative Specialty Services served merely to route investments from physicians to the MSOs. (Id. ¶¶ 37-41.)

While the government has not erred in its use of collective pleading, the complaint does fail to provide adequate notice of the time period at issue. As the parties appear to agree, the FCA statute of limitations precludes relief for false claims submitted prior to January 22, 2018 (six years prior to the filing of the complaint). See 31 U.S.C. § 3731(b). The complaint broadly describes the entire scheme, which operated from sometime in 2015 to October 2019. (FAC ¶¶ 114, 132.)[4] However, false claims submitted during the majority of that period are time-barred.

Although the government conceded in briefing and at

[4] While the first MSO was created in June 2017, the scheme existed beginning in 2015 in a different configuration utilizing organizations referred to as preferred placement memorandums. (See FAC ¶¶ 108-14, 238.)

oral argument that the six-year statute of limitations applies, the complaint must reflect that limitation in order to plead the "when" of the false claims it alleges violated the FCA. The complaint may, of course, reference events occurring throughout the life of the scheme in order to provide necessary context. But the government must identify when the reimbursement claims for which it seeks to recover damages were submitted, thereby providing defendants with "adequate notice to allow them to defend the charge." See Scheibe v. Livwell Prod., LLC, No. 23-cv-216 MMA BLM, 2023 WL 4414580, at *4 (S.D. Cal. July 7, 2023). This is because violations of the FCA are premised not on the entire scheme, but on the "claim[s] for payment" themselves. See Gen. Dynamics, 637 F.3d at 1055; see also United States ex rel. Brooks v. Trillium Cmty. Health Plan, Inc., No. 6:14-cv-1424 MC, 2017 WL 2805863, at *2 (D. Or. June 28, 2017) (the fact that the "majority" of examples of fraud given in FCA complaint occurred "outside the statute of limitations . . . represents a pleading deficiency [under Rule 9(b)] rather than a bar to relief as a matter of law").

Accordingly, because the court concludes that the government has failed to plead its FCA claims with particularity in this respect, the first through fourth claims will be dismissed with leave to amend.

IV. Unjust Enrichment & Payment By Mistake

The complaint also contains claims for unjust enrichment and payment by mistake, which the government may bring

alongside FCA claims pursuant to federal common law.[5] See United States v. Mead, 426 F.2d 118, 124 (9th Cir. 1970) (in action under False Claims Act, "the government's alternative theory of recovery is under the common law doctrine of payment by mistake," which "is available to the United States and is independent of statute"); United States v. California, 932 F.2d 1346, 1350 (9th Cir. 1991), aff'd, 507 U.S. 746 (1993) (collecting cases for proposition that "classic cases of unjust enrichment" can be brought under federal common law); United States ex rel. Humane Soc'y of the U.S. v. Westland/Hallmark Meat Co., No. 08-cv-00221 VAP OPX, 2010 WL 11464786, at *13 (C.D. Cal. Aug. 5, 2010) ("federal common law provides for reimbursement of federal monies improperly paid pursuant to federal programs"); United States v. Bellecci, No. 05-cv-1538 LKK GGH, 2008 WL 802367, at *6 (E.D. Cal. Mar. 26, 2008) (explaining that longstanding federal common law allows government to bring mistake of fact and unjust enrichment claims alongside FCA claims).

Because the government has failed to plead the underlying fraud with particularity, the unjust enrichment and payment by mistake claims -- which are premised on that fraud (see FAC ¶¶ 297-303) -- also fail. See Puri v. Khalsa, 674 F. App'x 679, 690 (9th Cir. 2017) (where an "unjust enrichment claim is based on fraud, it too is subject to Rule 9(b)"); cf. United States ex rel. Berntsen v. Prime Healthcare Servs., Inc., No. 11-

[5] Defendants argue that these claims must be dismissed because (1) unjust enrichment and payment by mistake are not available as freestanding claims under California law, and (2) the claims are barred by the California statute of limitations. However, as indicated by the cited case law, these claims are available to the government under federal common law.

cv-8214 PJW, 2017 WL 11636166, at *4 (C.D. Cal. Jan. 13, 2017) (declining to dismiss claims for unjust enrichment and payment by mistake as they were "derivative of the government's [adequately pled] False Claims Act claims"). Accordingly, the court will also dismiss the fifth and sixth claims with leave to amend.

IT IS THEREFORE ORDERED that defendants' motions to dismiss (Docket Nos. 21, 32, 33) be, and the same hereby are, GRANTED. The United States has twenty days from the date of this Order to file an amended complaint curing the statute of limitations issue consistent with this Order.

Dated: July 10, 2024

WILLIAM B. SHUBB
UNITED STATES DISTRICT JUDGE